and supplemental vein graft anastomoses relevant in graft survival? Eur J Cardiothorac Surg 1998;13:36-41.

12/8/91858

Reply to the Editor:

The left internal thoracic artery (LITA) has become the conduit of choice for myocardial revascularization, because it has been proved that early mortality and morbidity are low.[1-3] At our institution 98% of all surgical revascularizations of the myocardium are performed with an LITA on the left anterior descending artery (LAD). Perioperative or early postoperative malperfusion of the LITA is a rare complication of coronary artery bypass grafting and may lead to the potentially fatal LITA hypoperfusion syndrome, which is caused by an acute imbalance between myocardial demand and nutritional support through the LITA.[4-6] Since we changed the preparation technique of the LITA by using very-low electrocautery and dilatation of the LITA by intraluminal infusion of 1% papaverine solution, the incidence of LITA hypoperfusion syndrome has decreased significantly to 1% in 1997. Recently Pagni and associates[7] demonstrated on a dog model that the increased distance (3-4 cm) of the additional vein graft implantation to the LITA might be an important factor in maintaining ITA patency. The additional vein graft implantation described in our article was at least 3 cm distal to the LITA implantation performed.

Still, and as we do agree with Galea and associates, the additional vein graft to the LAD is the therapy of choice for LITA hypoperfusion syndrome.

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Use of Ultracision harmonic scalpel for isolation of intramyocardial coronary vessels during coronary revascularization of the beating heart

To the Editor:

Intramyocardial segments of coronary arteries are not only larger than other segments but also are frequently free of disease. For this reason and lack of any other suitable location, sometimes it becomes necessary to isolate this segment of the vessel. This is a relatively simple matter in an arrested and flaccid heart. However, it becomes a formidable surgical challenge in operations on the beating heart for the following reasons.

The dissection of intramyocardial arteries from surrounding fat and muscle fibers requires a small and bloodless field to identify, at times, vessels as small as 1 mm. During beating-heart coronary revascularization with a small moving target and the vessel obscured by surrounding fat and muscle fibers, a bloodless field, although attainable, is hardly achieved by

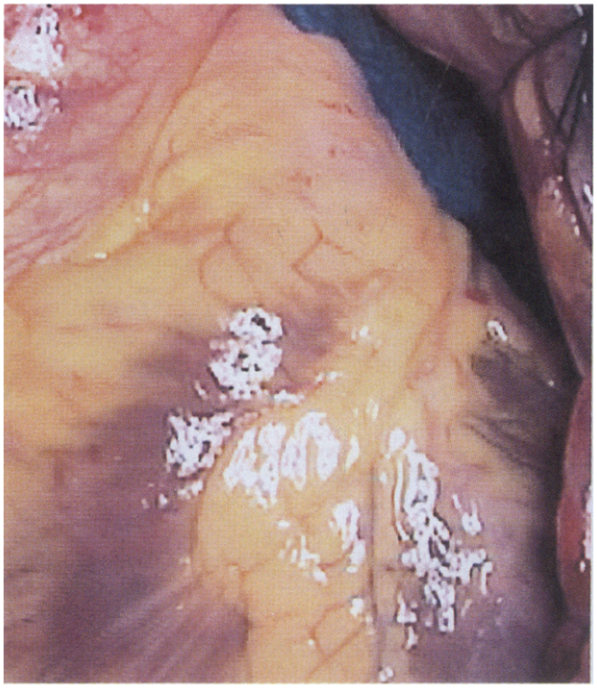

Fig 1. Intramyocardial left anterior descending coronary artery before division of myocardial fibers.